STD cases

Discharge

Male:

- Gonococcal : Profuse, thick, creamy, yellowish or yellowish-green.
- Non-gonococcal: Slight mucoid or mucopurulent
- Post-gonococcal: After Successful treatment of gonorrhea
- Prostatorrhea: single, no sexual act, straining

Female:

- Candidal: Thin, minimal, white, cheesy, odorless
- Trichomonas: Profuse, yellowish, watery, frothy, offensive
- Bacterial vaginosis:Thin, fishy, smooth, homogenous grayish

Case 1 (Master 11/2011)

A 25 years old male patient presented with painful joint swelling, red maculopapular lesions around joints of extremities & gave history of profuse yellow creamy discharge.

What is the possible cause of this condition & its management?

Answer:

Arthritis dermatitis syndrome following gonococcal urethritis

Key points:

- Profuse yellow creamy discharge (gonococcal)
- Painful joint swelling, red maculopapular lesions (features of septicemia)

Investigations:

- Demonstrating gonococci from oral, rectal or genital sites
- Blood & synovial fluid culture → gonococci
- Direct fluorescent antibody test (+ve >50%) from skin lesion

Treatment:

- Hospitalization
- Benzyl penicillin, 10 million units daily IV for 3 d followed by amoxicillin 500 mg orally for 4 d
- Ceftriaxone 1 g IM or IV /d, Spectinomycin 2g twice /d IM or ciprofloxacin 500mg/12 h for 7 d
- Treatment of concurrent chlamydial infection: by a course of tetracycline
- Trace all sexual contacts.

Case 2 (Master 11/2006)

Male patient 25 years old complained of profuse yellowish urethral discharge. Patient gave history of sexual act since one week.

a) What is your diagnosis?

b) Investigations?

c) Treatment?

Answer:

a) Gonococcal urethritis

Key points:

- Profuse yellowish urethral discharge
- One week (IP: 2d-2w)

b) Investigations (with short notes):

1. Urine tests
2. Smear
3. Culture
4. Confirmatory tests for identification
5. Serological diagnosis
6. Test for antibiotic sensitivity

c) Treatment:

General lines: avoid sexual excitation, intercourse, alcohol, self-examination, local anti-septic, trace & treat sexual partner

- Procaine penicillin 2-4 million units IM + probenecid 1 g orally
- Ampicillin or amoxicillin 3 g single dose orally + probenecid 1 g orally

Case 3 (Master 11/2011)

A 35 years old male patient complained of scanty watery discharge with mild dysuria 2 weeks after successful course for treatment of gonorrhea.

Answer:

Post-gonococcal urethritis (PGU)

Key points:

- Successful course for treatment of gonorrhea
- Scanty watery, mild dysuria→ non-gonococcal urethritis

After successful course for treatment of gonorrhea with penicillin or spectinomycin, 25-50% of cases developed NGU. C. trachomatis is more frequently associated with PGU. Patients with PGU have a double infection of gonorrhea & NGU. The latter will persist due to longer IP after gonorrhea have been eliminated. So, it is better to follow treatment of gonorrhea by a course of tetracycline

Case 4 (Diploma 5/2013) , (Diploma 4/2015) , (Diploma 11/2015)

A 33 years old man suffered from mild dysuria & mucoid urethral discharge. There is history of extramarital intercourse 3 weeks ago. Gram stained smear was negative:

a) What is your diagnosis?

b) What are the possible causes?

c) How can you treat such patient?

Answer:

a) Non-gonococcal urethritis

Key points:

- Mild dysuria & mucoid urethral discharge
- 3 weeks ago (longer IP 1-5 w)
- Gram stained smear was negative (abacterial urethritis)

b) Causes:

I) Sexually transmitted:

A) Non-specific urethritis: no cause can be detected

B) Specific causes:

- Chlamydia trachomatis
- Ureaplasma urealyticum
- Trihomonas vaginalis
- Candida spp
- Herpes simplex
- Bacteria-like group B streptococci
- Intraurethral causes: chancre, chancroid, LGV, wart, herpes

II) Non-sexually acquired urethritis:

- Bacterial UTI associated with urethritis
- Urogenital TB with urethritis
- Acute hemorrhagic cystitis
- Steven-Johnson syndrome
- Secondary to: urethral instrumentation, FB, renal stone

c) Treatment:

- Tetracycline 500 mg 4 times daily, avoid milk products which inhibit Tetracycline activity
- Doxycycline 100 mg twice daily for 7 days,
- Azithromycin 1 g single dose
- Ofloxacin 400 g orally twice daily for 7 days.
- Avoid sexual activity
- Treat sex partners
- Follow up

Case 5 (Diploma 11/2015)

A single 23 years old male complaining occasional urethral discharge that may follow urination, defecation & sometimes on straining. He denies any sexual relation. Urethral swab for Gram stain for gonococci was –ve.

a) What is your diagnosis?

b) What is the cause & management?

Answer:

a) Prostatorrhea

b) Cause: congested prostate due to unsatisfied sexual stimulation.

Reassurance

Advice him to get married

Case 6 (Master 11/2012)

A 28 years old married female complaining from scanty, cheesy thick discharge of 3 weeks duration. Patient is diabetic. She is complaining from intense valval itching, dysuria & dyspareunia.

a) What is the diagnosis?

b) How can you confirm the diagnosis?

c) How would you treat her?

Answer:

a) Genital candidiasis

Key points:

- Scanty, cheesy thick
- Diabetic (predisposing factor)
- Intense itching, dysuria & dyspareunia

b) Diagnosis:

Direct KOH: G-stained smear from vaginal wall shows G+ ve blastospores & pseudo or true hyphae

Culture on Sabouraud's glucose agar: colonies appear 1-3 days at (37°C), creamy, moist colonies, microscopic examination of colonies → clusters of budding cells.

c) Treatment:

1. Avoid PF
2. Vaginal pessaries:

- Miconazole, isoconazole nitrate, tioconazole 500 mg once at night or 200 mg for 3 days

- Nystatin 100,000 units intravaginally at bedtime 3 days

3. Male sexual partner: topical anticandidal cearm

Case 7 (Master 4/2013)

A 28 years old female complained from dysuria & dyspareunia of 3 weeks duration, also patient complained from **thick cheesy vaginal discharge** with vulval **itching**.

a) What are the DD? Genital candidiasis, other genital discharge

b) What is the management? See before

Case 8 (Master 5/2014)

A 26 years old female patient complaining of fever, malaise 2 months after she experienced an illegal intercourse 4 days after the sexual intercourse. Patient noticed purulent vaginal discharge & she neglect it. On examination, there was abdominal & adnexal tenderness with tenderness on motion of the cervix.

a) What is your diagnosis?

b) What are the etiopathogenesis & complications of this condition?

c) How can you treat this case?

Answer:

a) Pelvic inflammatory disease (PID)

Key points:

- Fever, malaise
- Purulent vaginal discharge
- Abdominal & adnexal tenderness

b) *Etiopathogenesis:* Spread of infection from the cervix to the tubes & ovaries through endomatrium & rarely via lymphatics.

Predisposing factors:

- After child birth or miscarriage
- Surgical instrumentation of uterus
- Intrauterine contraceptive device
- Previous attacks of PID
- Trichomonas vaginalis, it takes up gonococci & mycoplasma to pass to the cervix
- Sperms seem to be a vector to the micro-organisms
- Pressure changes at coitus

Complications:

- Short-term: perihepatitis, pelvic abscess
- Long-term: recurrence, chronic pain, infertility, ectopic pregnancy

c) Treatment:

1- Avoid predisposing factors

2- Sexual contacts should be traced

4- Hospitalization

4- Antibiotic therapy:

- Ampicillin 3 g orally with probenecid 1 g for uncomplicated gonorrhea
- Tetracycline 500 mg 4 times daily (or doxycycline 100 mg twice daily) for 10 days for chlamydial
- Metronidazole 500 mg tds for 10 days for anaerobic infections
- Cefoxitin 1-2 g IM 4 times daily for 4 days

Case 9 (Master 5/2015)

A 35 years old married woman had sex with her husband who came from a business trip to far east. 5 days later, she noticed a greenish yellow frothy vaginal discharge with pungent odor. Also, she had painful urination, vaginal itching & severe discomfort during intercourse. Her husband who used to have extramarital relations was not complaining of any sexual symptoms.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Trichomoniasis

Key points:

- Greenish yellow frothy vaginal discharge with pungent odor
- Itching, dysuria, dyspareunia
- Asymptomatic husband (asymptomatic carrier)

b) Causative agent: Trichomonas vaginalis

c) Full clinical picture:

In women:

- No or only minor symptoms
- Vaginitis: profuse, yellow, irritating, frothy & offensive discharge → marke vulvitis, dyspareunia, dysuria & frequency. It aggrevated by menses & pregnancy.
- On examination: red vaginal wall, strawberry cervix, vaginal PH is more alkaline (5-8)
- Trichomonas in pregnany may lead to preterm labor, premature membrane rupture

In men:

- The condition is usually asymptomatic (asymptomatic carrier)
- Urethritis
- Urcerative balanoposthitis

d) Management:

Investigations:

- Direct microscopic examination (wet-mounted preparation)
- Stained smear
- Cultures
- Exclude gonococcal, candidal or chlamydial infections
- Antigen detection test.

Treatment:

- Metronidazole 2 g orally single dose, or
- Tinidazole 2 g orally single dose
- Sexual partner should be treated
- Alcohol should be avoided

Ulcers

- Painful, soft →Chancroid
- Painless, indurated → Chancre
- Painless, inguinal multiple sinuses → lymphogeanuloma venereum
- Inguinal ulcer → Granuloma inguinale

Case 10 (Master 11/2011)

A 29 years old male patient complaining of small painless penile ulcer on the coronal sulcus of the penis few days later after unprotected intercourse, after 1 week he noticed also a large inguinal painful mattered swelling discharging pus from multiple sinuses

a) What is the diagnosis & DD?

b) What is the management?

Answer:

a) Lymphogeanuloma venereum

Key points:

- Painless penile ulcer
- Inguinal multiple sinuses
- 1 week (IP 1-3w)

DD: other causes of genital ulcers

b) Management:

- Doxycycline 100mg po bid at least 3 weeks
- Inguinal LN should be aspirated

Case 11 (Master 11/2013)

A 30 years old male presented with two kissing ulcers on the lower end of the glans penis of 6 days duration after an illegal sexual intercourse, ulcers were tender, with irregular shape, undermined edge, the base was soft & the floor covered with purulent discharge with suppuration of the regional LN.

a) What is your diagnosis?

b) What are the clinical varieties of this case?

c) Mention the diagnostic tests used to confirm this case?

d) What is your management?

Answer:

a) Chancroid

Key points:

- Kissing ulcers
- Tender
- Soft

b) Follicular, dwarf, transient, popular, giant & phagedenic.

c) Diagnostic tests (with short notes):

1. Direct smear
2. Culture
3. Ito-Reenstierna intradermal test
4. PCR testing & indirect IF
5. Biopsy

d) Management:

1. Azithromycin 1g orally single dose
2. Ceftriaxone 250 mg IM single dose
3. Ciprofloxacin 500 mg orally twice a day for 3 days
4. Erythromycin 500 mg orally 4 times a day for 7 days
5. Do not incise the bubos, only aspirate by a wide pore needle

Case 12 (Master 11/2012)

A 25 years old single male patient noticed the presence of small papules on his glans penis 7 days after intercourse. The papules changed after 2 days into painful ulcers. Examination of such lesions revealed shallow ulcers with undermined edge, irregular shape, soft & non-indurated kissing ulcers. The inguinal LN were enlarged.

a) What is the diagnosis?

a) What is the management?

Answer:

a) Chancroid

Key points:

- Painful ulcers
- Soft
- Kissing

b) see before

Case 13 (Diploma 11/2014) ,(Diploma 4/2016)

Male patient 28 years old presented by single painless penile ulcer since 10 days. The patient gave history of extramarital sexual relation 45 days ago. On examination the ulcer has slopping edge & indurated base with enlarged, discrete. Firm, painless, bilateral inguinal LN.

a) What is your probable clinical diagnosis?

b) What are the clinical DD?

c) How can you manage this case (laboratory diagnosis & ttt)?

Answer:

a) Chancre (primary syphilis)

Key points:

- Painless
- Indurated base
- 45 days (long IP 9-90d)

b) DD: Other causes of genital ulceration

c) Lab (with short notes):

1. Dark ground examination
2. Direct fluorescent antibody to TP
3. Serological tests
4. Biopsy
5. Intraermal treponema color test

Treatment:

- Benzathine pencillin 2.4 million units IM single dose, or
- Procaine penicillin 1.2 million units IM qd for 10 days

Alternative regimens for penicillin-allergic pt :

- Doxycycline 200 mg qd for 14 days, or
- Tetracycline 500 mg po qid for 14 days, or
- Ceftriaxone 1 g IM or IV for 8-10 days,or
- Azithromycin 2 g po single dose

Case 14 (Master 11/2006)

Female patient 25 years old complained of 2 kissing ulcers on the vulva. The ulcers were indurated & didn't bleed easily. The patient had bilateral painless, inguinal lymphadenopathy.

a) What is your diagnosis?

b) DD?

c) Treatment?

Answer:

a) Chancre

Key points:

- Indurated
- Didn't bleed easily (Endarteritis obliterans)
- Painless, inguinal lymphadenopathy

b) DD: other causes of genital ulcers

c) see before

Case 15 (Master 5/2015)

A college student, 20 years old, had sex with a female tourist from Europe. 5 days later, he developed 3 small papules surrounded by narrow red border which became filled with pus, in the groin region. These pustules ruptured, leaving painful opened ulcers which gradually enlarge & became deep.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Granuloma inguinale

Key points:

- Groin region
- Painful opened ulcers

b) Causative agent: Donovania granulomatis (Calymmatobacterium granulomatis)

c) Painless, indurated bright red granulomatous ass on genitalia. Inguinal swellings due to SC granuloma → pseudoboboes → inguinal ulcer.

Complications: urethral stricture, deformity, rectovesical fistulae, lymphatic obstruction, elephantiasis-like swelling of genitalia lower limbs. Scc on long standing cases. Seconfary bacterial infection → phagedenic ulcer.

d) *Investigations*:

- Stained smear (Wright's or Giemsa stain): Donovan bodies in mononuclear cells (safty-pin)
- Biopsy: to exclude carcinoma: hyperplasia of marginal epidermis, dense inflammatory infiltrate.

Treatment (at least 3 weeks):

Doxycycline 100 mg po bid

Alternative:

- Trimethoprim-sulfamethoxazole(160/800mg) po bid, or
- Ciprofloxacin 750 mg po bid, or
- Erythromycin 500 mg po qid, or
- Azithromycin 1 g po once weekl

Vesicles

Vesicles = Herpes progenitalis

Case 16

A 33 years old female complained from dysuria, dyspareunia & vaginal discharge with skin lesion affects the vulva of 6 days duration. On examination there was a group of vesicles on erythematous base affect the labia majora & clitoris.

a) What is the diagnosis?

b) How to confirm your diagnosis?

c) How to avoid recurrence for this case?

Answer:

a) Herpes progenitalis

- Key points: group of vesicles on erythematous base

b) Diagnosis (with short notes):

- Tissue culture
- Tzanck smear
- Specific serological tests
- PCR
- Biopsy

c)

1- Prevention:

- Disclosure of genital herpes infection to new partners
- Abstinence during outbreaks
- Correct & consistent condom use

2- Avoid any PF

3- Oral antiviral is initiated as soon as possible after the onset of lesions (with short notes).

4- Prophylactic ttt: continuos daily suppression therapy with antiviral medication, if the patient has ≥ 6 attacks/year. It reduces the reccurence by 75 %.

Famciclovir 250mg twice a day or valacyclovir 500 mg once a day,

HSV vaccines

Case 17 (Master 4/2011)

A 28 years old male complains from genital soreness, burning & painful micturation with constitional symptoms 5 days after sexual contact.

On examination, there were groups of vesicles with grayish yellow covering round the fraenal region of penis with enlarged tender inguinal LN.

a) What is your diagnosis?

b) What is the biggest worry faced by the patient's pregnant wife?

Answer:

a) Herpes progenitalis

- Key points: group of vesicles

b) Neonatal herpes simplex:

1- Congenital infection:

- Fetal death & spontaneous abortion
- Fetal serious multisystem disease at birth

2- Neonatal infection:

- During passage through birth canal & direct contact with maternally shed virus.
- Localized skin, eye or mouth disease
- Disseminated infection with encephalitis , fatal

Homosexual

Case 18 (Master 11/2011)

A 23 years old homosexual male suffering from loss of weight, diarrhea, pneumonia & a variety of skin infections for about 3 months.

a) What is your provisional diagnosis?

b) How can you confirm your diagnosis?

Answer:

a) HIV infection

Key points:

- Homosexual
- Loss of weight
- Diarrhea
- Pneumonia
- Skin infections
- 3 months

b) How to confirm the diagnosis:

Criteria for diagnosis:

I) Any 2 of the following persist for 3 months:

- Weight loss ≥ 10%
- Diarrhea
- Fever ≥ ° C
- Skin rash
- Profound malaise
- Oropharyngeal csandidiasis
- Oral hairy leukoplakia
- Multidermatomal herpes zoster

Plus

II) Any two laboratory abnormalities:

- Anemia, leucopenia, thrombocytopenia, lymphopenia
- Low number of T-helper cells <400/mm
- Helper:suppressor T-cell ratio < 1

- Depressed blastogenesis
- Elevated serum immunoglobulin level
- Cutaneous anergy

Laboratory diagnosis:

- HIV antibody assays (ELISA, Western blot)
- Detection of HIV antigen
- Isolation of HIV
- HIV-RNA detection

Case 19

A 29 years old homosexual man complaining from chronic diarrhea, prolonged fever for more than one month duration. On examination there was an extensive oropharyngeal candidiasis & multiple vascular nodules of Kaposi sarcoma present all over the body.

a) What is the diagnosis?

b) How to confirm your diagnosis?

c) What is the possible treatment?

Answer:

a) HIV infection

Key points:

- Homosexual
- Chronic diarrhea
- Prolonged fever
- Oropharyngeal candidiasis
- Kaposi sarcoma

b) see before

c) Treatment:

- Prevention & treatment of opportunistic infections & neoplasms
- Antiviral drugs

Case 20 (Master 5/2015)

A 30 years old homosexual male came to venereology clinic complaining of multiple swellings on his genital area. On examination, there was a major swelling on the anus of 10X15 cm blocking the anus which made defecation a difficult process. The swelling had fetid odor & bled on touch. Also, there were multiple small papules on his penis.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Condyloma acuminatum (anogenital wart)

Key points:

- Homosexual
- Major swelling on the anus
- Multiple small papules on his penis
- Fetid odor & bled on touch

b) Causative agent: Human papilloma virus

c) Full clinical picture:

Multiple , soft, skin-colored, verrucous discrete papules that occasionally coalesce into cauliflower-like masses.spontaneous regression occurs in 20-30%. There are 4 clinical types of genital warts:

1. Small popular
2. Cauliflower-like
3. Keratotic warts
4. Flat-topped papules/plaques

Sites: area with increased friction during intercourse

1. Male: frenulum, corona, glans penis, prepuce, shaft & scrutum
2. Female: labia, clitoris, periurethral area & perineum, associated vaginal & cervical lesions.
3. Both: perineal, perianal, anal canal, urethra, bladder

d) Investigations:

- Acetowhitening
- Histopathological examination

- Detection of HPV DNA by PCR
- Tests to exclude other STDs & HIV
- Sexual partner examination

Treatment:

I) Patient-applied agents:

- Podophyllotoxin
- Imiquimod 5% cream
- Green tea sinecatechins
- Topical cidofovir 1% gel

II) Clinician-administered theray:

- Crysurgery
- Podophyllin resin 20% in colodion
- TCA
- Surgical removal
- Electrocautary
- CO2 laser
- Intralesional interferon
- Topical 5-FU
- Immunotherapy

III) Combined therapy

IV) Treatment of anogenital premalignant lesions

V) Vaccine therapy

Case 21 (Master 4/2013)

A 19 years old passive homosexual man complained from pain during defecation with anal discharge 5 days after he experienced a sexual relation with active homosexual partner, on examination the anal opening appeared red with purulent discharge come from it.

a) What is the possible diagnosis?

b) How can you manage this case?

c) What are other investigations should be done for this homosexual patient generally?

Answer:

a) Gonococcal proctitis

Key points:

- Homosexual
- 5 days (short IP)
- Anal opening appeared red with purulent discharge

b) Investigations (with short notes):

1. Urine test
2. Smear
3. Culture
4. Confirmatory tests for identification
5. Serological diagnosis
6. Tests for antibiotic sensitivity

Treatment:

- Procaine penicillin 2-4 million units IM + probenecid 1 g orally
- Ampicillin or amoxicillin 3 g single dose orally + probenecid 1 g orally

Epididymis/scrotum

Case 22 (Master 5/2015)

A 20 years old male had sex with prostitute 10 weeks ago. He showed in venerology clinic with severe pain in the right side of scrotum with edema, redness & tenderness. He had fever for 2 days of 39 °C degree.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Acute epididymo-orchitis

Key points:

- Severe pain in the right side of scrotum
- Edema, redness & tenderness
- Fever

b) Causative agent:

STD: gonorrhea, non-gonococcal (C. trachomatis, mycoplasma)

Other causes:

UTI: E.coli, pseudomonas

Other: TB, schistosoma, mumps, brucellosis, filariasis, fungal

c) Full clinical picture:

1. Acute onset of fever, headache & malaise
2. Epididymitis is tender, swollen ± 2ry hydrocele
3. Suppuration may occur → sinus formation
4. Infertility: due to fibrosis or obstructionof epididymal duct or destruction of testis

d) Investigations (with short notes):

- Color –flow Doppler & scrotal ultrasonography
- Urethral gram stain
- Urine microscopy
- Testing for N.gonorrhea & C. trachomatis
- Urine culture

Treatment:

- Ceftriaxone 250 mg IM+ doxycycline 100 mg orally, twice daily for 10 days
- Treatment of sexual partner

Case 23 (master 4/2013)

A 21 years old male complaining from painful swelling in the scrotum of 3 days duration with fever & malaise. On examination, the right side of scrotum including the testis & epididymis are tender & swollen.

a) What is the possible diagnosis?

b) How to confirm your diagnosis?

c) What is the treatment?

Answer:

a) Acute epididymo-orchitis

Key points:

- Painful swelling in the scrotum
- Fever & malaise
- Testis & epididymis are tender & swollen.

b) see before

c) see before

Prostate

Case 24 (Diploma 5/2013), (Master 11/2015)

A 35 years old male complaining of dysuria, testicular & low back pain & premature ejaculation. Digital rectal examination revealed slightly enlarged tender prostate.

a) What is your diagnosis & clinical types?

b) How can you confirm the diagnosis?

c) What are treatment lines?

Answer:

a) Chronic abacterial prostatitis

Key points:

Prostatitis =

- Dysuria
- Testicular & low back pain
- Premature ejaculation
- Slightly enlarged tender prostate

- No fever & malaise , No soft or fluctuant areas → Not acute bacterial
- No morning drop → Not chronic bacterial
- 90% of symptomatic prostatitis patients are grouped in this category (Chronic abacterial prostatitis), The commonest

Clinical types:

Type I: acute bacterial prostatitis

Type II chronic: bacterial prostatitis

Type III: chronic abacterial prostatitis/ chronic pelvic pain syndrome

Type IV: asymptomatic inflammatory prostatitis

b) Diagnosis (with shoet notes):

- PR
- Prostatic smear examination
- Transrectal US
- Prostatic antibodies by ELISA

c) Treatment:

- 12-week of antimicrobial therapy may improve symptoms, despite the absence of bacterial infection
- NSAID
- Reassurance & minor tranquilizing drugs
- Advice to pass urine regularly

Syphilis

STD with skin rash = Syphilis

Case 25 (Master 5/2015)

A baby boy was born to a mother who had several miscarriages, abortions, still-birth pregnancies. He had rash on his palms & soles since birth. Later on, his mother noticed that he was not responding to normal or high pitched voices or sounds.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Congenital syphilis

Key points:

- Mother had several miscarriages, abortions, still-birth pregnancies
- Rash on his palms & soles
- Not responding to voices or sounds (nerve deafness)

b) Treponema pallidum

c) Full clinical picture (with short notes):

Early congenital syphilis

- General features of marasmus (Senile facies)
- Mucous patches
- Skin lesions
- LN
- Viscara
- Bone

Late congenital syphilis:

- Interstitial keratitis
- Nerve deafness
- Neurosyphilis

- Bone
- Clutton's joints
- Paroxysmal cold hemoglobinuria.

d) Investigations:

- Radiological examination of bones
- Dark-field examination
- Serological tests (blood taken from umbilical vein)

Treatment:

- Aqueous penicillin G 50,000 U/kg, IV /12 hours for the first 7 days of life, then /8h for 3 days.
- Procaine penicillin 50,000 U/kg IM /d for 10-14 days

Case 26 (Master 11/2012)

A 30 years old male patient complaining from bilateral & symmetrical skin rash of 2 weeks duration. The rash is non pruritic polymorphic & affects the trunk & both hands. He is also complaining from a patch on the oral mucosa & a big oral ulcer taking a snail track appearance.

a) What is the diagnosis?

b) How would you investigate him?

c) What is your treatment?

d) How would you follow this patient?

Answer:

a) Secondary syphilis

Key points:

- Bilateral & symmetrical skin rash
- Non pruritic, polymorphic
- Trunk & both hands
- Oral patch
- Snail track oral ulcer

b) Lab (with short notes):

- Dark ground examination
- Serological tests
- Biopsy

Treatment:

- Benzathine pencillin 2.4 million units IM single dose, or
- Procaine penicillin 1.2 million units IM qd for 10 days

Alternative regimens for penicillin-allergic pt :

- Doxycycline 200 mg qd for 14 days, or
- Tetracycline 500 mg po qid for 14 days, or
- Ceftriaxone 1 g IM or IV for 8-10 days,or
- Azithromycin 2 g po single dose

d) Follow up:

- Repeat serological tests 24 months after treatment
- CSF must be done at last follow up visit

Retreat if:

- Clinical signs & symptoms persist or recur (clinical relapse)
- Sustained 4-fold ↑ in titre of non-treponemal test (serological relapse)
- An initially titre, non-treponemal test fail to show a 4-fold↓ within a year→ patients treated as syphilis > 1 year

Drops of blood in the underwear

Case 27 (Master 11/2012)

A 21 years old male patient complaining from scanty discharge & sometimes he noticed some drops of blood in his underwear, he experienced an extramarital sexual intercourse about 6 months earlier. On examination of the urethral meatus a cauliflower small papule found in the opening of the urethra.

a) What is the possible diagnosis of this condition?

b) How can you treat this patient?

Answer:

a) Intraurethral wart

b) Treatment:

Medical trearment is useful for urethral warts located at accessible sites:

I) Patient-applied agents:

- Podophyllotoxin
- Imiquimod 5% cream
- Green tea sinecatechins
- Topical cidofovir 1% gel

II) Clinician-administered therapy:

- Crysurgery
- Podophyllin resin 20% in colodion
- TCA
- Surgical removal
- CO2 laser
- Intralesional interferon
- Topical 5-FU
- Immunotherapy

III) Combined therapy

IV) Vaccine therapy

Case 28 (Master 5/2015)

A 19 years old male had sex with a prostitute few days ago. He smelled her bad odor but did not mind about that. A few days later, he started to itch all over his body & noticed blood stains on his body & underwear.

a) What is your diagnosis?

b) What is the causative agent of this condition?

c) What is the full clinical picture?

d) How to manage such case (investigation & treatment)?

Answer:

a) Pediculosis pubis

Key points:

- Itch all over his body
- Blood stains on his body & underwear

b) Crab louse (phthirius pubis)

c) Full clinical picture:

- Itching is the main symptom
- Blood stains on the body & underwear
- There may be blue macules due to bites of the parasites (Maculae caeruleae)
- The affected sites: pubic area, lower abdomen, scrotum, perianal region may extend to axilla, thighs & eyelashes.
- The egg capsules (dark nits) are attached to the hairs by cement substance

d) Management:

- Gamma benzene hexachloride is applied once to be repeated after 1 week in heavy infestations.
- Malathion 0.5% lotion
- Crotamiton
- Trace & treat the sexual partner
- Investigations of other STDs